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Date notice sent to all parties:

May 19, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

APPEAL Transforaminal Epidural Steroid Injection at Bilateral L5-S1 w/Fluoroscopy APPEAL Monitored Anesthesia Care by CRNA.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Anesthesiology

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male with complaints of back pain. On 01/16/12, he was seen for evaluation. He stated he worked doing manual labor, and in xx, he was moving drums and developed low back pain. On exam, he had normal strength in the lower extremities on the left side, but there was marked weakness in the right gastrocnemius and soleus group. Right ankle reflex was absent. An MRI revealed a disc herniation on the right side at L4-5 with clear nerve root compression with a sacral cyst as well. On 09/10/12, the patient returned to clinic. It was noted then that he had undergone physical therapy, which gave him no significant relief, and he continued to have diffuse pain in his mid-back, low back, and going down his legs. It was noted then that he had a history of anxiety disorder, and the plan was

to arrange for him to be seen by a psychiatrist. On 05/12/14, the patient was taken to surgery for an L5-S1 anterior lumbar interbody arthrodesis, with application of instrumentation, PEEK cage at L5-S1, with bone marrow aspiration and the use of allograft and intraoperative neurological monitoring. On 01/28/15, a lumbar myelogram report was submitted, noting that there was a global fusion at L5-S1, and there were no extradural defects or neural mass effect, and there was no stenosis in the subarachnoid space. The L3, L4, L5, and S1 nerve root sleeves filled well and were symmetrical. There were no intradural extramedullary abnormalities. On 03/10/15, the patient was seen in clinic. It was noted he had undergone an L5-S1 laminectomy in 2012 and an L5-S1 fusion in 2013. He complained of left leg pain worse than right, and reported increased pain for 3 days after the myelogram. He also complained of associated suicidal ideation, and depressive disorder not elsewhere classified with a diagnosis. On exam, motor testing showed well-developed and symmetrical musculature in the bilateral lower extremities with no evidence of weakness at L1 to S1. There was no atrophy and muscle tone was normal. Bilateral patellae reflexes were rated at 1+/5 and bilateral Achilles reflexes were 0+/5. He had an antalgic gait. Straight leg raise while seated was positive bilaterally for radiating leg pain. He had a hypoalgesia in a bilateral S1 distribution. A bilateral L5-S1 lumbar selected nerve root block was recommended with fluoroscopic guidance to ensure appropriate injection placement and optimized diagnostic outcome, and it was noted there were no positive Waddell's signs or evidence of psychosocial pathology that would preclude performance of the recommended injection procedure. It was noted that due to the delicate nature of the procedure coupled with work in a sensitized or painful area around vital neurovascular structures in a patient with anxiety, anesthesia services were indicated for comfort and safety.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

On 03/18/15, a utilization review report non-certified the request for monitored anesthesia care by a CRNA transforaminal epidural steroid injection at bilateral L5-S1 with fluoroscopy. Criteria used for this was Official Disability Guidelines 11th Edition 2013, Low Back, Epidural steroid injections, therapeutic, and the rationale was that there was lack of documentation demonstrating this patient had significant weakness and radiculopathy not corroborated with imaging studies, as there is no evidence of pathology upon imaging. There is also no evidence of significant anxiety related to the procedure. There was lack of documentation demonstrating the patient had significant weakness. The request was non-certified. On 04/17/15, a utilization review report also non-certified the request for an appeal for a transforaminal epidural steroid injection at bilateral L5-S1 with fluoroscopy and monitored anesthesia care by CRNA. Criteria utilized was Official Disability Guidelines, 11th Edition, Low back, lumbar and thoracic therapeutic epidural steroid injections. The rationale given was that the documentation submitted for review did not include evidence of radiculopathy due to a herniated disc upon physical examination, and there was no additional documentation submitted to meet medical necessity. The recommendation was for non-

certification.

Official Disability Guidelines, Low back chapter, was utilized for this review, noting the purpose of an ESI is to reduce pain and inflammation, facilitating progress in more active treatment programs with reduction of medication use and avoiding surgery. This treatment alone offers no significant long-term functional benefit, however. Radiculopathy due to a herniated disc, but not spinal stenosis, must be documented. There should be objective findings on exam. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic tests. For this review, the records submitted include the 01/28/15 myelogram report, documenting a global fusion has been noted at L5-S1 and L3, L4, L5, and S1 nerve root sleeves fill well and are symmetrical. There are no extradural masses or neural mass effect, and there is no stenosis in the subarachnoid space. The records indicate that the patient was last examined on 03/10/15, prior to this request, and there was no atrophy and motor muscle tone and strength were normal. He did have a pinprick sensation decreased in the bilateral S1 distributions, and patellae reflexes were 1+/5 and Achilles reflexes 0+/5. Straight leg raise was positive for radiating leg pain. However, there is lack of an imaging study to document and corroborate objectively, this radiculopathy on physical exam. Therefore, it is the opinion of this reviewer that the request for an appeal for an transforaminal epidural steroid injection at bilateral L5-S1 with fluoroscopy is not medically necessary.

This request also includes a request for monitored anesthesia care by a CRNA. While the records indicate the patient does have a history of anxiety, as evidenced by the 09/10/12 progress note, the most recent records indicates that there is no psychological contraindications to the procedure. The injection procedure is not medically necessary. There is lack of medical necessity for monitored anesthesia care by a CRNA. Therefore, it is the opinion of this reviewer that the request for monitored anesthesia care by a CRNA is not medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[x] ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, low back and pain chapters

Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making

unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. (Trentman 2008) (Kim 2007) (Cuccuzzella 2006) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

3) Injections should be performed using fluoroscopy (live x-ray) for guidance.

4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks

5) No more than two nerve root levels should be injected using transforaminal blocks.

6) No more than one interlaminar level should be injected at one session.

7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.